

Subcommittee on Criminal Justice, Drug Policy and Human Resources

Opening Statement of Chairman Mark Souder

‘Methamphetamine Treatment: Availability and Effectiveness of Programs to Treat Victims of the Methamphetamine Epidemic’

June 28, 2006

Good afternoon and thank you for being here.

Today’s hearing will examine methamphetamine treatment programs – their availability and effectiveness for addressing the needs of meth victims and their communities.

I am very concerned about this issue; I fear there is currently a treatment vacuum when it comes to meth, despite the fact that the meth epidemic has swept across the country and especially devastated our nation’s western states and rural areas. I am worried that effective treatment for meth addiction is not available where people need it the most, because the communities most affected are the least equipped in their treatment capabilities to handle the special needs presented by meth users.

An oft-repeated assertion is that meth addiction cannot be treated. That is incorrect. It can be treated. We’ll hear from successful treatment recipients. But the availability of effective programs across the nation is difficult to measure. Moreover, without strong leadership from the White House Office of National Drug Control Policy to aggressively tackle this scourge, federal measures to address the treatment vacuum will languish, despite the tremendous toll this drug is having on our nation.

The meth epidemic has touched every state in the country, draining resources, causing serious environmental damage, and destroying lives. SAMHSA’s Drug Abuse Warning Network, known as DAWN, showed that in the early to mid-nineties, methamphetamine use was on the rise, and treatment episode data confirmed this: treatment admissions for meth use grew rapidly through the nineties, increasing five-fold between 1992 and 2002.

The most recent treatment episode data show that fifteen states have higher rates of admission for amphetamine use – largely meth – than for heroin or cocaine. In just those fifteen states, there were over 102,000 admissions for amphetamine treatment, versus the 73,000 combined admissions for heroin and cocaine. Nationwide, there were more than 151,000 admissions for amphetamine treatment.

To say that meth is highly addictive is an understatement, and it presents unique clinical challenges for treatment. Meth produces a short, intense “rush,” followed by a long-lasting sense of euphoria. Addiction to meth is caused by the way the drug alters the brain and leads the user to compulsively seek more meth. Chronic use of the drug also leads to increased tolerance, prompting the user to take higher and/or more frequent doses of the drug to get the same effect. Moreover, meth users may also develop severe psychotic and paranoid behavior. Meth users who do seek treatment often relapse and continue chronic meth use.

There are currently no medications that demonstrate effectiveness in treating meth addiction, but intense behavioral interventions have proven effective. The largest controlled study of meth treatment, conducted by the Center for Substance Abuse Treatment, demonstrated positive post-treatment outcomes for 60 percent of the treatment sample which reported no meth use and which had urine samples that tested negative for meth.

Nonetheless, traditional treatment programs for alcohol and marijuana are inadequate for dealing with the unique clinical challenges presented by this drug. Such treatment programs, sometimes the only treatment option available in the communities hardest hit by the meth epidemic, result in very poor post-treatment outcomes for meth users. And this represents our greatest challenge: how do we ensure that our federal treatment efforts are addressing the meth epidemic in measurable ways in the areas hardest hit by the scourge?

I look forward to hearing from our witnesses today about the current state of meth treatment options – how prevalent, how effective, and by what measure. In the areas where we are falling short, I hope our witnesses are prepared to offer some solutions.

I am particularly interested in the discussion with our Administration witnesses, who will present information on the federal efforts for developing, supporting and measuring meth treatment systems and programs. The Administration witnesses comprising our first panel are Dr. Bertha Madras, Deputy Director for Demand Reduction at the White House Office of National Control Drug Policy; Dr. Nora Volkow, Director, National Institute on Drug Abuse (NIDA), National Institutes of Health; and Charles Curie, Administrator of the Substance Abuse and Mental Health Services Administration (SAMHSA), and I’m most pleased to say a fellow Hoosier (one of two Hoosiers testifying today).

Witnesses on our second panel will present on-the-ground perspectives of treatment, both from the treatment provider side, and the recovered meth user side. This includes the second Hoosier witness, Leah Heaston, Director for Noble County (Indiana), Otis R. Bowen Center for Human Services; Richard Rawson, Associate Director, Integrated Substance Abuse Programs, UCLA; Russell Cronkhite, a recovered meth addict; Darren and Aaronette Noble, also recovered addicts, and their son Joey Binkley; Mr. Michael Harle, President and CEO, Gaudenzia, Inc.; and Mr. Pat Fleming, Director, Salt Lake County Substance Abuse Services.

Welcome to all of you.